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PERSPECTIVE

Spectrum, Procedural Feasibility, and the Value of a Surgeon's Opinion in Varying Gender-Affirming Surgeries

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Abstract

The understanding of gender has expanded contributing to gaps in gender-affirming care. Traditional gender-affirming surgeries focus on binary results, diminishing room for affirmation of other identities. Surgeons are faced with the challenge of deciding whether a variation of gender-affirming surgery can be safely performed per request. The ethical question of when a surgeon may say yes or no to these varying requests comes after the consideration of premorbid conditions, body habitus, age, social and family support, individuals' goals, and risk assessment. Preoperative evaluations must take into account surgical experience, barriers to care, increased risk profile, and the surgeon's personal biases.

Keywords: gender-affirming surgery; gender care; gender dysphoria; LGBTQ; transgender

Introduction

The traditional consensus for the treatment of transgender and nonbinary patients experiencing gender dysphoria has been to offer a mechanism for transitioning through hormonal therapy and or gender-affirming surgeries.[1] Today, our society and medical institutions have begun expanding their understanding of the gender identity spectrum and its fluidity. This spectrum includes individuals who identify as transgender, transfeminine, transmasculine, nonbinary, genderqueer, agender, and any combination or variation based on what the individual identifies with. Regarding gender fluidity, identity and expression may although shift or change throughout the course of life, which is an inherently normal human experience. Along with newfound acceptance comes the privilege and challenge of adapting the evolving field of gender-affirming care.

Currently, plastic and reconstructive surgeons along with other surgical subspecialists, such as urologists and gynecologists, are pioneering the field of gender-affirming surgery. Traditionally gender-affirming surgeries (GAS) focused on procedures, including vaginoplasties, phalloplasties, metoidioplasties, facial feminization, chondrolaryngoplasty, mastectomies, breast augmentation, and feminizing and or musicalizing voice surgeries.

With the broadened understanding of diverse gender expressions and identities, patients are presenting to providers with a variety of GAS requests. For example, traditional phalloplasty patients would undergo a complete hysterectomy, vaginectomy, with the option to undergo redirection of the urethra through the phallus or have a perineal urethrostomy (urinary orifice) at the base of the phallus. As an alternative, patients undergoing phalloplasty may request to maintain their vagina, uterus/ovaries as an option for fertility preservation, or the position of their natal urethra. Similarly, patients undergoing vaginoplasty may request to keep their phallus or testicles that is, as an option for delayed fertility preservation. Variation in top surgery requests may include undergoing breast reduction instead of mastectomy or mastectomy without nipple grafts. Patients may request surgery without the use of hormones as hormones may not be affirming to their gender identity.

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The arrival of these customizable options sheds light on an undefined boundary for legitimate versus unreasonable requests in the context of procedural complexity and achievable goals. While counseling patients, these boundaries must be established along with sound justification and considerations of risks versus benefits. The question raised here is when the gender-affirming surgeon can safely, ethically, and unbiasedly say "yes" or otherwise say "no" to the requests.

Safety Considerations

Regarding safety, consideration of elements such as marginally high body mass index (BMI) adds additional complexity. Although some authors consider the BMI requirements for GAS to be "ubiquitous" and "not empirically based," many patients are currently excluded from the GAS process based on the high BMI screening criteria set locally by different centers.[2] Surgeons may employ BMI limits for some GAS that is, vaginoplasties and or metoidioplasties to reduce operative risks, optimize surgical outcomes, and satisfy patients' surgical goals.

In the case of an obese individual interested in a metoidioplasty with urethral lengthening, to allow for standing micturition, counseling in regard to the limitations of the procedure should be carefully performed. The patient's neo-phallus may be obscured by a large mons or abdominal pannus such that the phallus may not be of sufficient length to exit the pants zipper. Even with an additionally performed monsplasty, the patient's goals may not be achievable. In addition, vaginoplasty patients with high BMIs may have difficulty with postoperative dilation. They may not be able to reach their vagina, and/or may insert the dilator into the urethral opening instead of the vaginal cavity. Inability to perform lifelong dilatation will guarantee the loss of the vaginal canal.

With these limitations in mind, surgeons should counsel their patients on these potential outcomes and provide alternative options or suggest postponement to allow for weight loss. Alternative options for an individual with a high BMI wishing to undergo vaginoplasty include shallow depth vaginoplasty (vulvaplasty), which would reduce operative time and risk and remove the risk for postoperative dilation issues.

Other surgical considerations include an increased risk due to the procedural variation itself. For example, a transfeminine or nonbinary individual may request a full-depth vaginoplasty but may want to retain their natal phallus and or testicles. As the penile skin and the scrotal sac is usually used to create the neo-vulva and vagina, the surgeon would most likely need to use additional skin grafts from lower abdomen, flanks or thighs, or consider the sigmoid colon or a partial peritoneal graft to create a full-depth vagina or rearrange the local perineal tissues to create the neo-vulva.

These techniques have higher complications rates than the conventional penile inversion procedure and the patient may be at an increased risk for iatrogenic injury of the retained phallus or testicles. Alternatively, a transgender man or a nonbinary individual may request a metoidioplasty with urethral lengthening without a concurrent colpectomy and colpocleisis in anticipation of using a front opening for intercourse or future vaginal deliveries. In this scenario, future intercourse, sex toys, and vaginal delivery will pose a significant risk of disruption of the urinary tract reconstruction performed for the urethral lengthening procedure.

Options such as these must be considered on a case-by-case basis as additional benefits may prove these procedures to be the most beneficial option. This may be seen with a transgender man willing to undergo C-section rather than vaginal delivery if the risk to their reconstructed urinary tract is considered to be too great. Under these variable circumstances it may be beneficial for the patient to further discuss expectations with their mental health professional (MHP), along with the surgeon, to ensure maximal awareness in the informed consent process and reduce the risk of postoperative regret.

Ethical Considerations

The ethical ground for the surgical team to say "No" to these varying requests, or the extent the surgeons should accommodate procedural alterations, has to be thoroughly assessed in a multidisciplinary manner. Considerations include the rationalization of such requests, premorbid conditions, body habitus, age, social and family support, patient's goals and expectations, and evidence-based risk assessment. Preoperative planning and evaluations must take into account surgical training and experience of the local team, barriers to care, potential increased risk profile, and the surgeon's personal or unconscious biases when considering the individuals specific demands for surgical options.

As there is no established ideal for GAS, there is a limited ability to compare surgical techniques and

outcomes.[3] Although the World Professional Association for Transgender Health provides standards of care, there is still a lack of mandated surgical techniques with acceptable low risks of complications. Although this allows for a high level of surgeon autonomy, there may be added variables between each surgeon based on their training and opinion of surgical outcomes.

A proposed solution is the creation of a national or worldwide database sharing which surgeons have performed certain procedures. This would allow for a path of communication between surgeons and their techniques. This may also provide an established tool for patients to seek further information on which surgeon they want and what variations are possible. In the meantime, it is crucial for these providers to consider their current training, patient expectations, and seek out fellow gender-affirming surgeons to discuss options.

Assessment of risk for each case should be scientific and seen in light of the individual surgeon's portfolio and prior patients' complications. These factors should be openly discussed with the patient. Although surgeons see the risk of complications based on potential future litigations, patients may take their chance of achieving their personal goals and expectations despite potential risks. These two systems should meet and be evaluated against each other during the preoperative assessments and counseling sessions.

Ethically, the preferences and beliefs of the providers may play an important role when considering the question as to which procedures can be safely performed per the patient's request. Regarding the degree of incorporated variability into procedures, the personal views and social constructs of surgeons may contribute to their decision-making.

For example, a nonbinary individual requesting a double incision mastectomy without nipple grafts may be refused care or dissuaded from their initial surgical desire because the surgeon is uncomfortable performing a top surgery without traditional nipple grafts. The surgeon may be uncomfortable due to a lack of understanding of gender expression or worry about an increased risk of patient regret postoperatively.[4] Alternatively, a nonbinary individual may request a variation of top surgery, such as preserving a smaller size breast with or without the addition of nipple grafts while avoiding a fully masculinized chest.

Providers must self-reflect on their personal beliefs and views to ensure they are not disregarding a patient's gender. Self-reflection may include questions such as "How do I understand/perceive this individual's gender? What are my beliefs regarding how I think their results should appear? If there is not a large increase in surgical risk, why am I hesitant to perform this surgery?" Surgeons may consider, with the patient's consent, discussing the matter with their MHP or other GAS team members to mitigate concerns about postoperative regret. If the conflict is unresolvable between the patient and surgeon, the surgeon should provide a referral to another capable surgeon without dissuading the patient, especially in cases of an unchanged or decreased procedural risk.

This referral process may be difficult as the availability of gender-affirming surgeons who have appropriate expertise is inadequate. With the increase in requests for procedural variations along with general GAS, there is a disproportionally lower number of trained professionals available regionally. Across the United States, just >650 gender-affirming surgeons are performing a variety of GAS. The location of these surgeons regionally does not reflect patient distribution contributing to barriers to GAS access. Researchers found it was difficult to confirm which procedures were performed by the surgeons, their credentialing, and sometimes even location, based on webpage discrepancies.[5]

This limitation in access and accurate information contributes to which procedures may be available to patients based on their location, educational level, insurance providers, and even their income. These issues may also be addressed through the creation of a national database as mentioned previously for resolving and providing the unstandardized techniques. The lack of availability and or access to GAS places increasing pressure on the surgeon to fulfill patient requests despite safety or ethical conflicts.

Bias Considerations

Similarly, to ethical considerations, surgeons must be able to provide unbiased care without compromising safety. This includes the ability of the surgeon to resist patient pressure when requested to perform a procedure they are untrained in or with an unacceptably high risk. The patient's insistence on certain treatment options (i.e., a specific combination of surgeries) may advance to threats of self-harm. This may be augmented further in cases where an alternative provider is nonexistent within proximity to offer a second opinion. In these cases, it may be beneficial for the surgeon to work with the MHP or primary care provider to ensure the patient has proper support if their requests must be denied due to safety or unachievable goals.

Conclusion

In conclusion, the positive advancements in the acceptance of gender expression are exposing technical and ethical gaps in the field of GAS. Within gender-affirming practices, it is important to take into account regional and social determinants of health regarding each patient as it may impact their understanding of and access to their requested procedures. With the growing number of variations possible in GAS, it is crucial for practitioners to honestly address their capabilities, knowledge, and inherent biases. Multidisciplinary gender-affirming care should be individualized per patient to maximize positive GAS outcomes. Part of this care includes understanding the justification behind patients' requests alongside weighing the risks and benefits of the procedure.

As this field is still in its infancy, we must prioritize more comparative evidence-based outcome analyses to fully assess the risks of deviations in the case of GAS. Expanding surgical skills, improving GAS training, and broadening surgical flexibility to respect legitimate requests from patients are vital. This includes maintaining consideration for the risks and benefits of each additional part of the surgery. These aspects are cornerstones for a successful and satisfying outcome with a reduced risk of postoperative complications or regret.

Authors' Contributions

Conceptualization by N.W. and A.H.J. equal; investigation by N.W. lead; supervision by A.H.J lead; writing—original draft by N.W. lead; writing—review and editing by A.H.J. lead.

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References

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 3rd edition. American Psychiatric Association: Washington, DC; 1980.
2. Brownstone LM, DeRieux J, Kelly DA, et al. Body mass index requirements for gender-affirming surgeries are not empirically based. Transgend Health 2021;6(3):121–124; doi.org/10.1089/trgh.2020.0068.
3. Walton AB, Hellstrom WJ, Garcia MM. Options for masculinizing genital gender-affirming surgery: A critical review of the literature and perspectives for future directions. Sex Med Rev 2021;9(4):605–618; doi: 10.1016/j.sxmr.2021.07.002.
4. Esmonde N, Heston A, Jedrzejewski B, et al. What is "nonbinary" and what do I need to know? A primer for surgeons providing chest surgery for transgender patients. Aesthet Surg J 2019;39(5):NP106-NP112; doi: 10.1093/asj/sjy166.
5. Cohen W, Maisner RS, Mansukhani PA, et al. Barriers to finding a gender-affirming surgeon. Aesthetic Plast Surg 2020;44(6):2300–2307; doi: 10.1007/s00266-020-01883-z.

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Abbreviations Used

BMI = body mass index
GAS = gender-affirming surgeries
MHP = mental health professional